STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155230	B. WING		03/22/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R		HESTER BLVD	
DOSEDI	JD VILLAGE			IOND, IN 47374	
ROSEBC	ID VILLAGE		RICITIV	OND, IN 47374	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F000000					
	This visit was	for a Recertification and	F000000	The creation and submission	of
	State Licensur	e Survey		this plan of correction does no	t
	Ctato Liconoai	o curvoy.		constitute an admission by this	s
	Cumray datas.	March 10, 10, 20, 21		provider of any conclusion set	
		March 18, 19, 20, 21		forth in the statement of	
	and 22, 2013			deficiencies, or of any violation	n of
				regulation. This provider	
	Facility numbe	er: 000135		respectfully requests that the	
	Provided numb	ber: 155230		2567 plan of correction be	
	AIM number:	100266820		considered the letter of credib	e
	/ (IIVI Halliber.	100200020		evidence and request a desk	
				review in lieu of post	
	Survey team:			re-certification on or after	
	Sharon Lasher	r RN, TC		4/10/13. Rosebud Village	
	Angel Tomlins	on RN		respectfully requests the state	
	Barbara Gray	RN		consider the following evidenti information be considered in	ary
	Leslie Parrett I			deleting the deficiency F 325.	
	Loono i airou i			Rosebud Village is requesting	2
	0			paper IDR review. The current	
	Census bed ty	pe:		2567 statement of deficiencies	
	SNF/NF: 65			omits pertinent facility informa	
	Total: 65			and therefore misrepresents the	
				services administered by the	
	Census payor	type:		provider. F 325 Nutrition	
		14		Federal Regulation states:	
		40		Based on a resident's	
				comprehensive assessment,	
		11		the facility must ensure that	a
	Total: 6	65		resident §483.25(i)(1)	
				Maintains acceptable	
	These deficien	icies also reflect state		parameters of nutritional	
	findings cited i	n accordance with 410		status, such as body weight	
	IAC 16.2.			and protein levels, unless the	e
	1, (0 10.2.			resident's clinical condition	
		4/04/40 0		demonstrates that this is not	:
		4/01/13 by Suzanne		possible; and §483.25(i)(2)	
	Williams, RN			Receives a therapeutic diet	
				when there is a nutritional	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/22/2013		
ROSEBU	ROVIDER OR SUPPLIER D VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE COMPLETION DATE		
				problem. State Operations Manual Interpretive Guidel for F 325 Acceptable parant of nutritional status" refers to factors that reflect that an individual's nutritional status adequate, relative to his/her overall condition and progno "Avoidable/Unavoidable" fatto maintain acceptable parameters of nutritional status of "Unavoidable" means that resident did not maintain acceptable parameters of nutritional status even though facility had evaluated the resident's clinical condition and implemented interventional risk factors; define and implemented interventional and evaluated the impact of interventions; and revised the approaches as appropriate. "Insidious weight loss" refers gradual, unintended, progre weight loss over time. End-of-Life Resident choice and clinical indications affect decisions about the use of a feeding tube at the end-of-life resident at the end of life manue an advance directive addressing his or her treatm goals (or the resident's surrour representative, in accordation with State law, may have manuel decision). Decreased appears and altered hydration are common at the end of life, and or require interventions others.	ines neters o sis osis osis osis illure attus: the gh the and ed ons dent d ored ithe ne " • s to a ssive es et a fe. A ay nent ogate ance ade a tite and do		

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	OF CORRECTION	IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 03/22/2013		
	ROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
				than for comfort. Multiple orgaystem failure may impair the body's capacity to accept or digest food or to utilize nutrie. Thus, the inability to maintain acceptable parameters of nutritional status for someone who is at the end-of-life or in terminal stages of an illness of the an expected outcome. Cand services, including comformeasures, are provided based the resident's choices and a pertinent nutritional assessment. The facility can help to supposintake, to the extent desired a feasible, based on the inform from the assessment and on considering the resident's choices. If individualized approaches for end-of-life can are provided in accordance with a care plan and the resident choices, then the failure to maintain acceptable paramet of nutritional status may be a expected outcome for resident with terminal conditions. To deficient practice statement states: Based on observation interview, and record review, facility failed to follow or implement new interventions resident with weight loss for residents reviewed for weight of 5 who met the criteria for weight loss. (Resident #50). Evidence to Refute the Find Resident 50 1. Resident #50 was admitted to the facility or 7/21/2009. Resident's primar diagnoses are bilateral renal	nts. et the may are out ad on ent. out and ation re vith out's ers nots he to the total of 2 total of 2 total of 2 total of 3 tota		

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	OF CORRECTION	IDENTIFICATION NUMBER: 155230	A. BUILDING B. WING	00	COMPLETI 03/22/20	ED	
	ROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) OMPLETION DATE	
				artery stenosis, type II diabet hypertension, chronic renal insufficiency, carotid artery disease, history of constipation Alzheimer's dementia with behavioral disturbances, and insomnia. (Attachment A). Resident #50 dietary physicial orders included the following regular diet with large breakfapeanut butter and jelly sandwat bedtime, salt substitute peresident request and offer bedtime snack. (Attachment 3. Resident #50 nutritional assessments completed by the Registered Dietician included following; meds, labs and vitamins reviewed by hospice orders to discontinue or chan (Attachment C) 4. Resident nutritional care plan included following, see attachment. (Attachment D) 5. Resident received an order for hospice services which states; may a resident to hospice, to keep resident comfortable, PRN medications, monitor pain, so mattress, may discontinue calcium supplement with vita D, may d/c CBC and LFT's laevery March and September March 8 th, 2013. (Attachment 6. Resident # 50 health was deteriorating as evidence from the social service notes, and nursing notes dated 2/6/13, 2/11/13, 3/07/13, and 3/20/13 (Attachment F) 7. The recoreflects that Resident 50 has experienced a 7 pound weight	on, 2. an ast, vich r A) ne I the e with ge. #50 the dmit coop min bs on nt E) m		

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i .				(X3) DATE SURVEY
AND PLAN OF CORRECTION	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		00	COMPLETED
	155230	A. BUILDING B. WING		03/22/2013
			DDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR	SUPPLIER		ESTER BLVD	
ROSEBUD VILLAGE			ND, IN 47374	
(X4) ID SUM	IMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH)	DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG REGULA	FORY OR LSC IDENTIFYING INFORMATION)	TAG		5.112
TAG REGULA	IORY OR LSC IDENTIFYING INFORMATION)		loss between April 2012 and A 2013. However all appropriate measures were taken to ensure this Resident was provided wire adequate nutrition and encouraged to consume mealismacks and fluids of her choice (Attachment G). 8. Resident food intake is monitored daily evidence by daily vitals reports which includes all of the reside meal intakes for the last 3 1/2 months to current date (Attachment H). 9. Resident #50 labs were monitored as evidence by routine labs (Attachment J). 10. Resident #50 annual nutritional assessment were completed a stated that resident's personal goal weight is 125#. RD's assessment indicates that resident #50 ideal body weigh between 108-132# (Attachment K). Conclusion: Residents #8 weight and food intake were being monitored. Resident #5 experienced unavoidable weigh loss due to the resident's deteriorating physical conditionand the acceptance of participation in the Hospice Program. The resident's labs were drawn and monitored. The resident had order dietary sna The facility made continuous dietary changes and intervent to help the resident achieve the highest practicable well being. The facility provided the reside with assistance to eat. Therefore, Rosebud Village does not beli	April re th s, e as s, ents t and t is nt 50's 0 ght n ecks. ons eir ent ore,

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	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/22/2013		
	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)			
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	it should have been cited for 325, and therefore requests 325 be deleted. Thank you your consideration. Joni Ho HFA Executive Director	r F s F for		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 CO			COMPL	ETED
		155230	B. WIN			03/22/	2013
			р. W II (ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.			HESTER BLVD		
ROSEBU	ID VILLAGE			RICHMOND, IN 47374			
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000241	483.15(a) DIGNITY AND RI	TERFOT OF					
SS=E	INDIVIDUALITY	ESPECT OF					
	_	promote care for residents					
	-	in an environment that					
		ances each resident's					
	dignity and respe	ct in full recognition of his					
	or her individualit	=					
	Based on inter	view and record	F00	0241	The creation and submission of		04/10/2013
	review, the faci	ility failed provide care			this plan of correction does no		
	in a manner tha	at promoted dignity,			constitute an admission by this		
	related to the fa	ailure to answer call			provider of any conclusion set forth in the statement of		
	lights in a timel	y manner and provide			deficiencies, or of any violation	n of	
	_	manner for 11 of 26			regulation. This provider		
	,	viewed regarding if they			respectfully requests that the		
		enough staff available			2567 plan of correction be		
		and assistance			considered the letter of credible	le	
		one without waiting a			evidence and request a desk review in lieu of post		
		idents #39 #54 #82			re-certification on or after		
	` `	74 #5 #25 #62 & #32).			4/10/13. F 241DIGNITY AND)	
	#3 <i>1</i> #40 #64 #	74 #3 #25 #62 & #32).			RESPECT OF INDIVIDUALITY		
		la.			The facility must promote care	for	
	Findings includ	le.			residents in amanner and in a	n	
					environment that maintains or		
	•	he record of Resident			enhances each resident's digr		
		3 at 2:10 p.m. indicated			and respect in full recognition		
		liagnoses included, but			his or her individuality. What corrective action(s) will be	ı	
	were not limited	d to, degenerative joint			accomplished for those		
	disease, pain, a	arthritis, anxiety, panic			residents found to have been	,	
	disorder, depre	ession and history of			affected by the deficient		
	right proximal h	nip fracture.			practice? *Residents#39 #54		
					#82 #57 #46 #84 #74 #5 #25 #	/ 62	
	The Minimum I	Data Set (MDS)			& #32 were not harmed by		
		r Resident #39 dated			alleged deficient practice. *All		
		ted the following: the			staff has been provided with re-education related to call ligh	nt	
	•	S (Brief Interview for			response time and expectation		
		•			of facility that all staff is to ans		
	ivieritai Status)	was a 15, with a range			call lights, conducted by		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJI	LDING	00	COMPLETED
		155230				03/22/2013
			B. WIN		ADDRESS CITY STATE ZID CODE	
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE	
DOOFDI	ID \				HESTER BLVD	
ROSEBU	JD VILLAGE			RICHIM	OND, IN 47374	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	of 13-15 indica	iting the resident was			DNS/designee on April 10, 20	13.
		act, the resident			*All residents #39 #54 #82 #57	7
		sive assistance of two			#46 #84 #74 #5 #25 #62 & #3	2
	· ·	sfer, walk in room-			call lights are being answered	
	l · · ·				timely by staff. How will you	
	1	occur, and required			identify other residents having	_
		stance of one person			the potential to be affected b	
		oilet use, and personal			the same deficient practice a what corrective action will be	
	hygiene.				taken. * Residents who reside	
					this facility have the potential t	
	Interview with	Resident #39 on			be affected by the alleged	
	3-18-13 at 10:	56 a.m. indicated it			deficient practice. * All staff h	as
		staff a long time to			been inserviced by the Directo	• • • • • • • • • • • • • • • • • • •
		Il light. Resident #39			Nursing and/or designee on ca	
		_			light response time and facility	,
		pedroom was located at			expectations of all staff answe	ring
		hall and staff tell her			call lights by April 10, 2013. *	Call
	they cannot se	e her call light.			light response audits will be	
	Resident #39 i	ndicated there had			conducteddaily on all 3 shifts t	ру
	been several ti	imes it has taken up to			the Director of Nursing and/or	
	two hours for t	he call light to be			designee to capture response	
	answered.	o			time on each shift. What	
	anoworou.				measures will be put into pla or what systemic changes yo	
	2 \ Davious of t	he record of Decident			will make to ensure that the	ou
	l '	he record of Resident			deficient practice does not	
		3 at 2:30 p.m. indicated			recur? *Facility expectation	that
		diagnoses included, but			all staff must answer call lights	
	were not limite	d to, macular			All staff has been inserviced b	
	degeneration,	osteoarthritis,			the Director of Nursing and/or	
	osteoporosis, l	nypertension, visual			designee on appropriate call li	ght
		ait impairment and			response time and facility	
	history of frequ	•			expectation that all staff must	
	1				answer call lights, conducted by	ру
	The MDS acco	essment for Resident			April 10, 2013. * Call light	ato d
					response audits will be conducted	
		13, indicated the			daily on all 3 shifts by the Dire of Nursing and/or designee to	CiOI
		resident's BIMS was a			capture response time on each	,
	13, with a rang	je of 13-15 indicating			shift. *DNS/designee will cond	
	the resident wa	as cognitively intact,			onini. Distoracoignice will cond	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155230	B. WIN			03/22/2013
NAME OF B			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			2050 CI	HESTER BLVD	
ROSEBU	JD VILLAGE			RICHM	OND, IN 47374	_
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	rounds to monitor call light	DATE
		ty occurred only once			response time daily on all 3 sh	ifts
		e assistance of one			to ensure call lights are answe	
	I -	room - did not occur,			in a timely manner. * The	
	locomotion on				Director of Nursing is responsi	ble
	· ·	f one person, dressing -			for compliance. *	ato.
		stance of one person,			Non-compliance with appropria call light response time will res	
		ensive assistance of			in further education, and/or	<u> </u>
		d personal hygiene -			disciplinary action. How will t	he
	extensive assis	stance of one person.			corrective action(s) be	
	l.,				monitored to ensure the	
		Resident #54 on			deficient practice will not rec	ur,
		30 a.m. indicated it			i.e., what quality assurance program will be put into place	2
		staff an hour to			* An Accommodation of Needs	
	_	nts. Resident #39			CQI tool will be utilized by	
		curs on all shifts at the			Director of Nursing/designee	
	facility.				weekly x 4 weeks, monthly x 2 months and quarterly X1 for at	
					least 6 months. * Audit tools the	
	l '	he record of Resident			do not exceed threshold of 909	
	#82 on 3-21-13				will be submitted to the CQI	
		esident's diagnoses			committee and action plans wi	II
	•	vere not limited to,			be developed as needed.	
	•	compression fracture of				
		ody, dry eyes, lumbar				
	spinal stenosis					
	osteoarthritis a	na aepression.				
	The MDS assa	ssment for Resident				
		13 indicated the				
	following: trans					
		one person, walk in did not occur, and				
	1	·				
	_	use and personal				
		nsive assistance of one				
	person.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155230	B. WIN			03/22/2013	
	PROVIDER OR SUPPLIEF	2	•	2050 CH	ADDRESS, CITY, STATE, ZIP CODE HESTER BLVD OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROVINER'S DI AN OF CORRECTION	DROVIDERIS N. AV OF GODDECTION	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			DATE
IAG	Interview with 13-19-13 at 10:2 had to wait for bathroom for u resident indica wait that long that and this had call incontinent of h. 4.) Review of the included, but we cerebral vasculosteoporosis, he degenerative included, but we cerebral vasculosteoporosis, he degenerative in the 4.) The MDS assetting that the 4. The MDS assetting the 4. The MDS	Resident #82 on 27 a.m. indicated he assistance to go to the p to one hour. The ted he was unable to o go to the bathroom aused him to be his bladder. The record of Resident 3 at 11:00 a.m. esident's diagnoses were not limited to, lar accident (stroke), hypertension and bint disease.		IAG	DERCENCTY		DATE
	call light.						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	COMPL		
ANDILAN	or connection	155230		LDING		03/22/	
		100200	B. WIN		PPPPGG GYMY GM MP GYP GODD	00/22/	2010
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE HESTER BLVD		
ROSEBU	ID VILLAGE				OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	5 \ Paviaw of th	ne record of Resident					
	,	B at 2:00 p.m. indicated					
		liagnoses included, but					
		d to, cerebral vascular					
	accident (strok	e), bladder cancer,					
	anxiety, pain a	nd depression.					
		ssment for Resident					
		5-13 indicated the					
	_	esident's BIMS was a					
	_	e of 13-15 indicating as cognitively intact,					
		sive assistance of two					
		room, personal					
		essing - extensive					
		ne person, and toilet					
		assistance of two					
	people.						
	l 4	Danidant #40 an					
		Resident #46 on 4 a.m. indicated it took					
		e to answer call lights.					
		ndicated it takes					
		20 minutes for staff to					
		l light. Resident #46					
		could not wait that long					
		hroom. Resident #46					
	-	ad bladder cancer and					
	felt that her bla	dder was "weak".					
	Resident #46 in	ndicated she knew how					
	_	ff to answer her call					
	_	she would time it by					
	her clock on the	e wall or her watch.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE S COMPLI		
		155230	B. WIN			03/22/	2013
	PROVIDER OR SUPPLIEF	2		2050 CH	DDRESS, CITY, STATE, ZIP CODE HESTER BLVD OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR		TE	COMPLETION
TAG	Confidential in 3-20-13 at 9:56 was not always the residents ti Confidential in 3-20-13 at 3:18 was not enoug repositioning, i skin care to resmanner. Staff were already we lights could be indicated it could	terview with staff #1 on 6 a.m. indicated there s enough staff to to give		TAG	DEFICIENCY)		DATE
	3-20-13 at 3:18 residents' call lanswered time indicated wher giving care the lights going off answer them, land the middle of gresident. Confidential in 3-21-13 at 1:48 residents did nassistance in a 6.) An intervie Resident #84,	terview with staff #4 on B p.m. indicated ights cannot be ly. Confidential staff #4 in aides were in a room y could hear the call it, but were unable to because they were indiving care to another sterview with staff #5 on 5 p.m. indicated the ot receive care and in timely manner. It was conducted with on 3/18/13 at 9:52 A.M. Itstated "I feel they are					

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PRINTED: 04/15/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155230	A. BUILDING B. WING			COMPLETED 03/22/2013	
	ROVIDER OR SUPPLIER		J. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE HESTER BLVD		
(X4) ID	ID VILLAGE SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	OND, IN 47374 PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
	they can and the Sometimes the and such." Resishe would turn staff would commit will be just a leave her room would return 10 and sometimes. Resident #84's on 3/22/13 at 4 included, but winability to ambigue to vitamin I diabetic neurop. Resident #84's Data Set (MDS 12/26/12, indicated Resident #84 hounderstand and others. She so Interview for Meindicating she will she required extraorders, and to walk. She was 7.) An interview of the some standard to the solution of the	record was reviewed, :30 P.M. Diagnoses ere not limited to, ulate with neuropathy 3-12 deficiency and eathy. admission Minimum) assessment, dated ated the following: ad the ability to d was understood by ored 15 on her Brief ental Status (BIMS), was cognitively intact. extensive assistance of					
	A.M. Resident "sometimes I pr	#74 stated ut my call light on but					

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Event ID: R0KF11

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155230	B. WIN	IG		03/22/	2013
NAME OF F	PROVIDER OR SUPPLIER	}		STREET A	DDRESS, CITY, STATE, ZIP CODE		
					HESTER BLVD		
ROSEBU	JD VILLAGE			RICHMO	OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		s. I will yell out that I					
	. •	he bathroom and then					
		ne shows up to take					
	me to the bath	room."					
	Dooidant #741-	rooped was revisioned					
		record was reviewed,					
		3:49 A.M. Diagnoses					
	· ·	vere not limited to,					
		ntia, osteoarthritis,					
		rtension, congestive					
	neart fallure, al	nd chronic debility.					
	Resident #74's	admission MDS					
		ated 1/11/13, indicated					
	· ·	Resident #74 had the					
	ability to under						
	1	others. He scored 12					
		ndicating his cognitive					
		derately impaired. He					
		sive assistance for bed					
		er, and toilet use. He					
		sive assist of one					
		. He was continent of					
	his bowel and						
		Diagaoi .					
	8.) An intervie	w was conducted with					
	l '	n 3/18/13 at 11:00 A.M.					
	l '	as queried if she felt					
		ugh staff available to					
		got the care and					
		needed without					
		a long time. Resident					
		tta say no." She					
		vaited approximately					
		ring busy times.					
	1	J ,	ı				1

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155230		A. BUII B. WIN	LDING	00	COMPL 03/22/	ETED	
	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE HESTER BLVD OND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	on 3/20/12 at 1 included, but w multiple scleros pulmonary dise myelitis with se diabetes, and of the sesident #5's assessment, daindicated the following had the ability the understood by on her BIMS, in cognitively intakent without having the sesident #25, of A.M. Resident #25 semetimes a lot they're busy." It is she used the brown the selection of the selection in the selectio	ecord was reviewed, 1:33 A.M. Diagnoses ere not limited to, sis, chronic obstructive ease, transverse condary paraplegia, chronic pain syndrome. Significant change MDS eated 12/31/12, sollowing: Resident #5 so understand and was others. She scored 15 edicating she was ect. She required ect of two persons for fransferring and occur. She required ect of one person to W was conducted with on 3/18/13 at 11:46 eat #25 was queried if fras enough staff ke sure she got the france she needed fro wait a long time. Itated her wait was ong time, because Resident #25 indicated edpan most of the time fransferred with the use					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 03/22/	ETED
	ROVIDER OR SUPPLIER			2050 CH	DDRESS, CITY, STATE, ZIP CODE HESTER BLVD OND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	on 3/22/13 at 4 included, but we acute respirator and end stage. Resident #25's assessment, do the following: It ability to understood by on her BIMS, in status was more required extens persons for bed to to to the following on the required extens persons for bed to to the following of the fol	admission MDS ated 2/15/13, indicated Resident #25 had the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE :	ETED	
		155230	B. WIN			03/22/	2013
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
ROSEBL	JD VILLAGE				HESTER BLVD OND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	arthritis, and back					
	problems.						
	 Resident #62's	s quarterly MDS					
		dated 1/8/13, indicated					
	•	Resident #62 had the					
	_	rstand and was					
	1	others. He scored 11					
	on his BIMS, i	ndicating his cognitive					
	status was mo	derately impaired. He					
		d assistance of 1					
	•	l mobility, transfer, and					
		was occasionally					
		urine. He required					
	supervision wi	th set up help to walk.					
	11) The rece	rd of Resident #32 was					
	,	/20/13 at 2:00 p.m.					
		s diagnoses included,					
		mited to diabetes,					
		cy, coronary artery					
		nic back pain and					
	osteoarthritis.	•					
		s MDS, assessment,					
		2, indicated the					
	following:						
		Interview for Mental					
	-	score of 13-15,					
	indicating cog						
	· ·	ensive assistance with					
	two+ person p	•					
		and corridor, extensive h one person physical					
	assist	n one person priysical					

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Facility ID: 000135

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/22/2013	
	PROVIDER OR SUPPLIE	R	2050 0	ADDRESS, CITY, STATE, ZIP CODE CHESTER BLVD MOND, IN 47374	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	- toilet use, limperson physical current toileticurinary continincontinent bowel continent of the bowel continent of the wheelchair commode transthe wheelchair commode. As #32 stood up surine before sist on the bed the bowel commode transthe wheelchair commode. As #32 stood up surine before sist on the bed the bowel commode transthe wheelchair commode. As #32 stood up surine before sist on the bed the bowel commode transthe commode. As #32 stood up surine before sist on the bed the bowel commode transthe be	enter assistance, one all assist and program, no nence, occasionally ence, frequently bowel ervation on 3/20/13 at ident #32 was observed hair facing her bed side asferring herself from a to the bed side soon as Resident she was incontinent of the got turned around to side commode. Tryiew on 3/20/13 at ident #32 stated "the usy here they don't all lights for a long time, so one to 2 hours before and I can't wait that my watch on and I know			ATE
	get help here to do to get to he over and hour.	d "it takes a long time to they have too much to er and a lot of times it is			
1	3.1-3(t)				

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	OF CORRECTION	IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPI 03/22	LETED			
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374						
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE			

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Facility ID: 000135

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	JLTIPLE CC	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DDIC	00	COMPL	ETED
		155230	A. BUII			03/22/	2013
			B. WIN		ADDRESS STATE OF SORE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					HESTER BLVD		
ROSEBU	D VILLAGE			RICHM	OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	IE.	DATE
F000311	483.25(a)(2)						
SS=D	TREATMENT/SE	RVICES TO					
	IMPROVE/MAINT						
		n the appropriate treatment					
		naintain or improve his or					
		fied in paragraph (a)(1) of					
	this section.						
	Based on obse	rvation, interview and	F00	0311			04/10/2013
		the facility failed to			F 311 TREATMENT/SERVICE	S	
		tive services for			TO IMPROVE/MAINTAIN ADL	.S	
	ambulation for						
		habilitation of 16					
	residents who i	met the criteria for			A resident is given the		
	rehabilitation.	(Resident #32)			appropriate treatment and		
					services to maintain or improve		
	Findings includ	۵.			his or her abilities.		
	i mamgo molad						
	The record of F	Desident #20 wee					
		Resident #32 was					
		20/13 at 2:00 p.m.					
	Resident #32's	diagnoses included,			What corrective action(s) will	ı	
	but were not lin	nited to, diabetes,			be accomplished for those		
	urinary urgency	y, coronary artery			residents found to have been		
	, , ,	ic back pain, and			affected by the deficient	1	
	osteoarthritis.	io baok pairi, aria			practice? * Resident #32 was	not	
	บรเฮบสเนาแร้.				harmed by alleged deficient	HUL	
					practice.*All staff inserviced or	1	
	Resident #32's	MDS (Minimum Data			restorative programs on April 1		
	Set) assessme	nt, dated 12/15/12,			2013.*Resident #32 is	,	
	indicated a BIM	IS (Brief Interview for			participating in physical therap	١V	
		assessment score of			per physician's order. How will	-	
	•	e of 13-15 indicating			you identify other residents		
		_			having the potential to be		
	-	The MDS also			affected by the same deficier	nt	
		dent #32 needed			practice and what corrective		
	extensive assis	stance with one			action will be taken. * Reside	nts	
	person's physic	cal assistance for			who reside in this facility have		
	ambulation.				potential to be affected by the	-	
					alleged deficient practice. * Al	I	
			I		'		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	V DIM DDIO	,	00	COMPL	ETED
		155230	A. BUILDING	ī		03/22/	2013
			B. WING	DEET A	DDDECC CITY CTATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIEF	8			DDRESS, CITY, STATE, ZIP CODE		
חססבטיי					HESTER BLVD		
KOSEBU	ID VILLAGE		RIC	اااال س	OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAC	j .	DEFICIENCY)		DATE
	Resident #32's	care plan, dated			staff inserviced by the Director	of	
	12/17/12, indic	ated "Problem,			Nursing and/or designee on		
		assistance with ADLs			restorative programs and		
		aily Living) related to			maintaining ADLs on April 10,		
	•	bility. Goal, resident			2013* All residents in facility w be assessed for need of a	/III	
		-			restorative program and		
	-	neat, clean appearance			implement program as needed	l by	
	•	equate time for resident			April 10, 2013.	. Uy	
	-	sk, assist/provide oral					
	care twice daily	y and as needed,			What measures will be put in	nto	
	encourage res	ident to do as much for			place or what systemic		
	self as possible	e, assist to complete			changes you will make to		
	•	ed, refer to therapies as			ensure that the deficient		
		ed, set up required			practice does not recur? * All		
	•	• •			staff inserviced by the Director	of	
	equipment with	iiii reacii.			Nursing and/or designee on		
					restorative programs and		
		1:20 p.m., Resident			maintaining ADLs on April 10,		
	#32 was obser	ved transferring by			2013* Director of Nursing and		
	herself from he	er wheelchair to her bed			designee will assess all reside in facility for need of a restorat		
	side commode	. She took small steps			program and implement progra		
	and was slow l	out did transfer herself			as needed by April 10, 2013.		
	from the wheel	chair to the bed side					
	commode.				*MDS coordinator and/or		
	oommode.				designee will reassess any		
	During on inter	riou on 2/21/12 of			resident who refuses restorative		
	_	view on 3/21/13 at			to ensure restorative needs ar	е	
	1:30 p.m. LPN				being met and determine		
	,	!) never walks. I don't			acceptance of restorative		
	think she want	s to."			programs.		
					* MDS coordinator and/or		
	During an inter	view on 3/21/13 at			designee will conduct rounds t	0	
	_	sical Therapist #12			ensure residents are receiving		
	indicated Resid	•			restorative programs as		
		m Physical Therapy on			assessed.* The MDS coordina	itor	
	_	•			and/or designee is responsible		
		lischarged from the			compliance related to restorati		
	Restorative pro	ogram on 1/18/13.			program initiation. How will th	е	
					corrective action(s) be		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155230	B. WIN			03/22/	2013
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	ζ.		2050 CI	HESTER BLVD		
	JD VILLAGE				OND, IN 47374		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE
	Resident #32's				monitored to ensure the deficient practice will not rec		
		licated 15 minutes of			i.e., what quality assurance	ui,	
	•	Range of Motion), on			program will be put into place	e?	
		d 1/14, 2013 and 15			* An Accommodation of Needs		
	minutes of a w	alking on 1/12, 1/13			CQI tool will be utilized by		
	and 1/14, 2013	3.			Director of Nursing and/or designee weekly x 4 weeks,		
	During a sector	miow on 2/22/42 -4			monthly x 2 months and quart	erly	
	_	view on 3/22/13 at			X1 for at least 6 months. * Aud		
		A #10 indicated the			tools will be submitted to the C		
		lk Resident #32 and			committee and action plans w	ill	
	stated "I think s	she is on restorative."			be developed as needed if threshold of 90% is not met.		
	During an inter	view on 3/22/13 at					
	_	ident #32 indicated the					
		t her up and walk her.					
		over here from the					
		they have walked me					
		t 40 feet and it felt good					
		d to be walking. I am					
	•	e able to walk if they					
	don't walk me.	•					
	don't walk me.						
	During an inter	view on 3/23/13 at					
	_	sical Therapist #13,					
		why (Resident #32)					
		the Restorative care.					
		times on two different					
		resident refuses 3					
		ee days we drop them					
	from Restorativ	ve.					
	During an inter	view on 3/23/13 at					
	2:05 p.m., the	DON indicated there					
	was no docum	entation of Resident					
	#32 being amb	oulated after 1/14/13 by					

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	OF CORRECTION	IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CC A. BUILDING B. WING	00		LETED 2/2013			
	PROVIDER OR SUPPLIEI JD VILLAGE	₹	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE			
	nursing.								
	3.1-38(a)(2)								

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155230	A. BUII B. WIN			03/22/	2013
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	t			HESTER BLVD		
DOSEBI I	D VILLAGE				OND, IN 47374		
NOSEBO	DVILLAGE			KICI IIVI	OND, IN 47374		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000315	483.25(d)	DDEVENTUIT DESTADE					
SS=D		PREVENT UTI, RESTORE					
	BLADDER Based on the res	ident's comprehensive					
		facility must ensure that a					
		ers the facility without an					
		er is not catheterized unless					
	_	ical condition demonstrates					
	that catheterization	on was necessary; and a					
		continent of bladder					
		ate treatment and services					
		tract infections and to					
	possible.	normal bladder function as					
	-	ervation, interview and	E00	0315			04/10/2013
		the facility failed to	100	0313	F 315 NO CATHETER,		04/10/2013
		•			PREVENT UTI, RESTORE		
	thoroughly ass	•			BLADDER		
		aches for bladder					
	_	f 3 residents reviewed					
		ning of 6 residents who					
	met the criteria	for bladder function.			Based on the resident's		
	(Resident #32	and #83)			comprehensive assessment, the	ne	
					facility must ensure that a resident who enters the facility	,	
	Findings includ	le:			without an indwelling catheter		
	J				not catheterized unless the		
	1.) The record	of Resident #32 was			resident's clinical condition		
	•	20/13 at 2:00 p.m.			demonstrates that catheterizat	ion	
		diagnoses included,			was necessary; and a resident	t	
		nited to, diabetes,			who is incontinent of bladder		
					receives appropriate treatment		
		y, coronary artery			and services to prevent urinary tract infections and to restore a		
		ic back pain and			much normal bladder function		
	osteoarthritis.				possible.	ao	
		MDS (Minimum Data					
	Set) assessme	nt, dated 12/15/12,					
	indicated the fo	ollowing:					
	- BIMS (Brief Ir	nterview for Mental			Miles Assume Att.	•	
	,				What corrective action(s) will	l	

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Facility ID: 000135

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155230	B. WIN			03/22/2013
		1	J. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	8			HESTER BLVD	
ROSEBL	JD VILLAGE				OND, IN 47374	
		TAMEN CONTROL STORY CONTROL			I	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	·	DATE
	Status), 15, a s				be accomplished for those residents found to have been	
	indicating cognition intact				affected by the deficient	'
	- transfer, exte	nsive assistance with			practice? * Resident #32 and	
	two+ person physical assist				#83 were not harmed by alleg	
	- walk in room	and corridor, extensive			deficiency practice.	
	assistance with one person physical					
	assist	,			* Resident #32 and #83 were	
- toilet use, limited assistance, one					reassessed and approaches	
	person physica	·			developed to enhance bladder	r
	' '				training.	
- current toileting program, no					* All stoff was presided	
	1	ence, occasionally			* All staff was provided re-education on how to identify	,
	incontinent				toilet programs for each	y
		ence, frequently			resident. How will you identify	,
	incontinent of t	powel			other residents having the	′
					potential to be affected by th	e
	Resident #32's	MDS assessment,			same deficient practice and	
	dated 10/6/12.	indicated Resident #32			what corrective action will be	e
	· ·	ntinent of urine and			taken. * Residents who reside	in
	always contine				this facility have the potential t	to
	alwayo ooniine	int of bowen.			be affected by the alleged	
	Decident #2016	care plan dated			deficient practice. * All staff w	as
		care plan, dated			inserviced by the Director of Nursing and/or designee on	
	· ·	ated "Problem,			toileting programs on April 10,	
		sk for incontinence due			2013. * Audits will be conducted	
	to extensive as				weekly to ensure CNAs are	
	(Activities of Da	aily Living), diagnoses			carrying CNA assignment she	ets
	of urinary urge	ncy. Goal, Resident			on them during work hours.*	
	will be free fror	n adverse effects of			Director of Nursing and/or	
	incontinence.	Approach 1/23/13,			designee will reassess all	
	toilet upon rising, before or after meals, before bed and as needed (also provide assistance per her request), assess and document skin				completely incontinent resider	nts
					with 3-day voiding patterns to	
					ensure all residents needing bladder retraining have	
					appropriate interventions.	
					appropriate interventions.	
		kly and as needed,			What measures will be put in	nto
		ontinent care as			place or what systemic	
	needed, check	every 2 hours for				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED				
		155230	A. BUILDING B. WING		03/22/2013				
			_	EET ADDRESS, CITY, STATE, ZIP CODE	1				
NAME OF P	PROVIDER OR SUPPLIEF	8		0 CHESTER BLVD					
ROSERU	JD VILLAGE			HMOND, IN 47374					
					r				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)				
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRI					
TAG		LSC IDENTIFYING INFORMATION)	TAG		DATE				
	incontinence, o	•		changes you will make to					
	abnormal findii	· ·		ensure that the deficient	All				
	physician and	observe for signs of		practice does not recur? . * Staff wasinserviced by	All				
	urinary tract inf	fection: decreased		theDirector of Nursing and/or					
	output, concen	trated urine,		designee on toileting program					
	abdominal/flank pain, difficult/painful			and use of CNA assignment					
	urination, frequency, change in			sheets on April 10, 2013. * Au	udits				
mental status, fever, increase in				will be conducted weekly to					
incontinence."			ensure CNAs are carrying CN	NA					
incontinence.			assignment sheets on them						
On 3/20/13 at 1:20 n m. Recident #32			during work hours.						
	On 3/20/13 at 1:20 p.m. Resident #32			* Director of Nursing and/a-					
		in her wheelchair		* Director of Nursing and/or designee will reassess all					
	facing her bed	side commode		completely incontinent reside	nts				
	transferring he	rself from the		with 3-day voiding patterns to					
	wheelchair to t	he bed side commode.		ensure all residents needing					
	As soon as Re	sident #32 stood up,		bladder retraining have					
		tinent of urine before		appropriate interventions.					
		around to sit on the							
	bed side comm			* Director of Nursing and/or					
	bed side comin	loue.		designee will add intervention	is to				
	During on inter	wiow on 3/21/12 of		the CNA assignment sheets.* The Director of Nurs	ina				
		view on 3/21/13 at		is responsible for compliance					
		sident #32 stated "I		related to ensuring toileting					
		the bed side commode		programs are being followed.	*				
		e. Just like this		Non-compliance of toileting					
	morning the CI	NA said she would		programs by staff may result	in				
	bring the bed p	oan but she didn't come		further education, and/or					
	back so I had t	o get up by myself and		disciplinary action. How will t	the				
		de commode. I don't		corrective action(s) be					
	make it and go some on the floor because once I get up I can't always			monitored to ensure the	0.11				
				deficient practice will not re i.e., what quality assurance	· ·				
		ey don't come in and		program will be put into pla					
		-		* An Accommodation of Need					
		e to go to the bathroom		CQI tool will be utilized by					
	I just go mysel	т."		Director of Nursing and/or					
				designee weekly x 4 weeks,					
	During an inter	view on 3/21/13 at		monthly x 2 months and quar	terly				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155230	B. WIN	G		03/22/	2013
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					HESTER BLVD		
ROSEBU	ID VILLAGE			RICHM	OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-	#11 stated "no, we			X1 for at least 6 months. * Aud tools will be submitted to the C	-	
	•	to use the bed side			committee and action plans wi		
	commode on a regular basis but sometimes she does call for assistance."				be developed as needed when		
					threshold of 90% is not met.		
	During an interview on 3/22/13 at						
	·	IA #10 indicated the					
	_	Resident #32 up to					
		le commode most of					
	the time, but they provide assistance per her request.						
		. 0/00/40					
	_	view on 3/22/13 at					
	•	ADON (Assistant					
	Director of Nur	•					
		vas on a toilet program					
	•	sing, before or after					
	•	ped and as needed					
		ssistance per her					
	request).	001					
		83's record was					
	· ·	/21/13 at 8:56 A.M.					
	_	uded, but were not					
		iratory failure, chronic					
	•	monary disease,					
	_	irt failure, end stage					
		and chronic pain					
	syndrome.						
	Didt #00!	admin alon Minters					
		admission Minimum					
	`	s) assessment, dated					
	· ·	ated the following.					
		ad the ability to					
	understand and	d understood others.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE COMPL		
		155230	A. BUI B. WIN	LDING		03/22/	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER JD VILLAGE	t.		2050 CH	HESTER BLVD OND, IN 47374		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	,		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE	DATE
		nited assistance of one					
	l ⁻	mobility, transfer, and					
		was always continent					
	of his bladder.	•					
	supervision with walk.	h set up help only to					
	waik.						
	A care plan for	Resident #83, dated					
	•	ated the following:					
	1	dent is at risk for					
incontinence due to: limited assist							
with activities of daily living (ADL's).							
		I-Resident will be free					
		effects of incontinence.					
	1	ssess and document weekly and as needed.					
		ontinent care as					
		k every 2 hours for					
	incontinence.	_					
		ngs and notify MD.					
	Observe for sig	gns of urinary tract					
	infection."						
	D						
		significant change					
		ent, dated 1/29/13, bllowing. Resident #83					
		to understand and					
		ers. He required					
		stance of 1 person for					
		ansfer, and toilet use.					
	He was occasi	onally incontinent. He					
		oileting program e.g.					
		ting, prompted voiding,					
		ning. He required					
	ıımıted assistar	nce of 1 to walk.					

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	of correction (155230) To Deficiencies (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/22/2013			
	PROVIDER OR SUPPLIER JD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	An interview with the Assistant Director of Nursing (ADON) on 3/22/13 at 12:10 P.M., indicated if a resident began having episodes of incontinence, the facility would request labs to see if an acute medical condition was present. The resident would be treated according to what abnormal labs pertained to incontinence. The resident would be referred to therapy for an assessment and if there was a true change in incontinence, the resident would be referred to restorative. An interview with the ADON on 3/22/13 at 2:28 P.M., indicated Resident #83 had not had any lab draws related to his incontinence. She indicated she read nursing notes daily and was not aware of his incontinence. She indicated his incontinence was not addressed because his incontinence episodes were sporadic, and not continual. She indicated if he was having continual incontinence, he would have been referred to therapy. She indicated he had not been referred to therapy related to his incontinence. She indicated he was not on a toileting schedule or a toileting restorative program.						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 03/22	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
	Nursing (DoN). P.M., indicated informed Reside episodes of indicated she is residents continuappears on the The Bladder Programmer of the DoN, on 3/2 indicated the four the policy to programmer of admission change in continuous of admission change in continuous of admission completed if the of continence in catheter is remishould be checked uring the night the voiding pattern overseeing the pattern 5.) To Coordinator/Urice informed in the pattern 5.) To Coordinator/Urice in the pattern 5.0 To Coordinator/Urice in the pattern	he MDS nit Manager should ling patterns on a daily						

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155230	B. WIN	G		03/22/	2013
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					HESTER BLVD		
ROSEBU	ID VILLAGE			RICHMO	OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO THE APPROPR		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	d continence status. >					
		ed at the end of the 1st					
	_	nt is totally incontinent					
	and cannot be	placed on a toilet or					
	bedpan (or use	a urinal) due to					
	physical limitati	ions and inability to					
	comprehend, d	iscontinue the voiding					
	pattern and pro	vide routine					
	incontinent care	e. >If it is determined					
	at the end of th	e 1st day the resident					
	is totally contin	ent, discontinue the					
	voiding pattern	. 6.) A bladder					
	assessment wi	ll be completed upon					
	admission, and	quarterly thereafter.					
	7.) After comple	etion of the 3 day					
	pattern the MD	S Coordinator/Unit					
	Manager will co	omplete the bladder					
	assessment ev	aluation and determine					
	if the resident is	s a candidate for one					
	of the following	. >Check and change					
	(routine inconti	nence care).					
	>Scheduled toi	leting program.					
		er re-training program.					
		nge: >If a resident is					
		ent and unable to be					
		let or bedpan, resident					
	· .	ked and changed					
		s. Scheduled toileting					
		voiding pattern can be					
		velop an individualized					
		c program, update the					
	care plan and r						
	•	ment sheets. >If a					
	_	cannot be determined,					
	J .	be toileted upon					
	. Joidon Conodic						

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155230	B. WIN	G		03/22/	2013
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
					HESTER BLVD		
ROSEBU	ID VILLAGE			RICHM	OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI		TE.	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	nd after meals, and at					
	bedtime. Bladd	_					
	,	resident should be					
		a bladder re-training					
	. •	following conditions are					
		g pattern could not be					
		Resident is mentally					
		aware of the need to					
		le to use the toilet,					
	commode, urin	•					
		entally and physically					
able to resist voiding to attempt a							
bladder retraining program. 2.) If a							
	resident is cons						
	candidate to a	bladder re-training					
	program, follow	the guidelines below:					
	>Consult with t	he resident/family					
	member for pe	rmission to start the					
	program. >Obt	tain a physician's order					
	to start the pro	gram. >Obtain an					
	order for a UA	and resolve any UTI					
	prior to beginni	ng the program.					
	>Based upon t	he resident's normal					
	and required flu	uid intake, determine					
	the amount of f	fluid to be provided					
	over the 24 hou	ur period. >Determine					
	a time in the ev	ening that no fluids will					
	be provided. >	Review the 3-day					
	voiding pattern	to determine a pattern					
	of voiding. >Be	egin bladder retraining					
	by instructing tl	ne resident to resist					
	voiding for the	amount of time that					
	was determine	d by the 3 day voiding					
	pattern. >Instr	uct resident to resist					
	voiding for 2 ho	ours until successful,					

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	of Correction identification number: 155230	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPI 03/22	LETED			
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE			
	then increase the intervals by an hour each day. >Update the care plan to include goals for voiding intervals and fluid regulation pattern. >Document fluids and voiding times on the I & O record" 3.1-41(a)(2)							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155230	B. WIN			03/22/	2013
NAME OF D	DOLUDED OD GLIDDI IED	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			2050 CI	HESTER BLVD		
	D VILLAGE				OND, IN 47374		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE	
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DLI ICILACI)		DATE
F000323	483.25(h) FREE OF ACCID	ENT					
SS=D							
	HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident						
	•	ains as free of accident					
		sible; and each resident					
	receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to implement a fall intervention of						
			F00	0323			04/10/2013
					F 323 FREE OF ACCIDENT		
					HAZARDS/SUPERVISION/DE	VI	
	•	lent within eyesight			CES		
	. •						
	while in a wheelchair for 1 of 3 residents reviewed for falls of 7						
		met the criteria for			The facility must ensure that the		
	accidents(Resi	dent #18).			resident environment remains as free of accident hazards as is		
					possible; and each resident		
	Findings includ	le:			receives adequate supervision	1	
					and assistance devices to prev		
	1.) Review of the	ne record of Resident			accidents.		
	#18 on 3-21-13						
		esident's diagnoses					
		•					
	· ·	rere not limited to,					
		eimer, osteoporosis,			l	_	
	hypertension a	nd vertebral			What corrective action(s) will	i	
	kyphoplasty.				be accomplished for those	_	
					residents found to have beer	1	
	The Minimum [Data Set (MDS)			affected by the deficient	not	
		r Resident #18 dated			practice? * Resident #18 was harmed during the alleged	1101	
					deficiency practice.* Resident	#18	
	1-22-13 indicated the following: transfer- extensive assistance of two				has all current fall intervention		
		room- activity did not			updated and implemented per		
	•	•			plan of care.*Resident #18 CN		
		ion on the unit- total			assignment sheets were upda	ted.	
	•	one person, dressing-			·		
		stance of one person,			How will you identify other		
	toilet use- exte	nsive assistance of two			residents having the potentia	tl	
			I				1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155230	B. WIN			03/22/2013
NAME OF I	DROVIDED OD GLIDDI IED		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			2050 CI	HESTER BLVD	
	JD VILLAGE				OND, IN 47374	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	l `	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE
	' ' '	sonal hygiene-			to be affected by the same	
extensive assistance of one person.					deficient practice and what corrective action will be take	un l
					* Residents who reside in	:II.
	The event repo	ort for Resident #18			this facility have the potential	to
	dated 3-8-13 a	t 7:45 p.m. indicated			be affected by the alleged	
	the resident wa	as found laying on her			deficient practice. * All staff	
		e foot of her bed on the			wasinserviced by the Director	
	floor in her bedroom. The resident				Nursing and/or designee on fa	
		eter by 3 centimeter			prevention and interventions of	
		•			April 10, 2013*Assistant Direct of Nursing and/or designee	TOT
skin tear (no description of a location of the skin tear) and 6 steri strips applied. The resident's right shoulder was swollen and the resident					updated all CNA assignment	
					sheets to ensure all appropria	te
					interventions were listed and	
					implemented. What measures	s
	~	n her shoulder was			will be put into place or what	t
		ysician was called and			systemic changes you will	
	1	right shoulder was			make to ensure that the	
	ordered.				deficient practice does not	
					recur? * All staff wasinservice	
	The event repo	ort for Resident #18			by the Director of Nursing and designee on fall prevention an	
	dated 3-9-13 a	t 10:30 a.m. indicated			interventions on April 10, 2013	
	the resident's s	steri strips were in			Audits will be conducted daily	
		ht side of her forehead.			all 3 shifts to ensure fall	
	·				interventions are in place for e	
	The Interdiscip	linary team (IDT)			resident by Director of Nursing	
		r Resident #18 dated			and/or designee.* The Directo	or ot
		p.m. indicated the IDT			Nursing is responsible for compliance related to fall	
		he resident's fall that			interventions. * Non-complian	nce
		8-13. The resident was			by staff to ensure appropriate	
					interventions are followed may	
		oor face down on her			result in further education, and	
	•	e foot of the bed. The			disciplinary action. How will the	he
		skin tear to the right			corrective action(s) be	
		e and her right shoulder			monitored to ensure the	
		he resident received 6			deficient practice will not rec	cur,
	steri strips to h	er forehead. The x-ray			i.e., what quality assurance program will be put into place	
	of the resident'	s shoulder was			Program win be put into place	

PRINTED: 04/15/2013 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374 REGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION) In egative for a fracture. Upon investigation of the resident's fall the staff had wheeled the resident to her room and went to get assistance from another staff to transfer the resident to her bed. The immediate intervention implemented was the staff were to assist the resident to remain within eyesight of staff until the resident was ready for transferring back to bed. The care sheet and careplan revised. During observation on 3-21-13 at 1:45 p.m. Resident #18 was sitting in her wheelchair in the TV room. There were no staff or other residents in the TV room. Resident #18 was not in eyesight of any staff. The TV room is located down the hall and around the corner from the nursing station. Resident #18 had a bandage on the	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
NAME OF PROVIDER OR SLIPPLIER ROSEBUD VILLAGE SUMMARY STATEMENT OF DEFICIENCIES DICHMOND, IN 47374 CORPLETION	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) negative for a fracture. Upon investigation of the resident to her room and went to get assistance from another staff to transfer the resident to her staff were to assist the resident to her staff were to assist the resident to remain within eyesight of staff until the resident was ready for transferring back to bed. The care sheet and careplan revised. During observation on 3-21-13 at 1:45 p.m. Resident #18 was sitting in her wheelchair in the TV room. Resident #18 was not in eyesight of any staff. The TV room is located down the hall and around the corner from the nursing station. RESIDENCY RICHARD REPROPABILE (X5) COMPLETION			155230				03/22/	2013
ROSEBUD VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MINT BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Regulatory of a fracture. Upon investigation of the resident's fall the staff had wheeled the resident to her room and went to get assistance from another staff to transfer the resident to her bed. The immediate intervention implemented was the staff were to assist the resident to remain within eyesight of staff until the resident was ready for transferring back to bed. The care sheet and careplan revised. During observation on 3-21-13 at 1:45 p.m. Resident #18 was sitting in her wheelchair in the TV room. Resident #18 was not in eyesight of any staff. The TV room is located down the hall and around the corner from the nursing station. Resident #18 had a bandage on the						ADDRESS, CITY, STATE, ZIP CODE		
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corner from the nursing station. Resident #18 had a bandage on the		eyesight of any	staff. The TV room is					
Resident #18 had a bandage on the		located down t	he hall and around the					
Resident #18 had a bandage on the		corner from the	e nursing station.					
			•					
right side of her forehead.			•					
Interview with CNA #5, #6 and #7 on		Interview with (CNA #5 #6 and #7 on					
3-21-13 at 1:55 p.m. indicated they			•					
			•					
were all assigned to care for Resident		_						
#18. CNA #5, #6, and #7 indicated								
they were not aware that Resident		•						
#18 was supposed to be within		• •						
eyesight of staff until she was ready			-					
to lay down. When queried how were		to lay down. W	hen queried how were					
fall interventions communicated to the		fall intervention	s communicated to the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: R0KF11

Facility ID: 000135

If continuation sheet Page 36 of 47

PRINTED: 04/15/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE COMPL		
THIS TEXT	or condition	155230		LDING		03/22/	
		.00_00	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/22/	
NAME OF I	PROVIDER OR SUPPLIEF				HESTER BLVD		
ROSEBUD VILLAGE					OND, IN 47374		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	ì ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	COMPLETION DATE
TAG		indicated it would be		TAG	BEFFEERET		DATE
		the care sheet. CNA					
		e care sheet at this					
	time, and it did						
		for Resident #18 to					
		eyesight of staff until					
	she was ready	• •					
	in the state of th	,					
	Interview with t	the Assistant Director					
	Of Nursing (AD	OON) on 3-21-13 at					
	1:57 p.m. indic	-					
	responsible to	update the CNAs' care					
	sheets with fall	interventions to					
	communicate t	he residents' fall					
	interventions to	the staff. The ADON					
	indicated she o	lid not add the fall					
	intervention of	keeping Resident #18					
	within eyesight	of staff until the					
		eady to lay down. The					
		d she would update					
		care sheet at this					
	time.						
	De milion est est	Man an 0 00 40 -1 0 45					
		ation on 3-22-13 at 9:45					
		#18 was sitting in her					
		he TV room with her					
		d her eyes closed. The					
		ot within eyesight of					
	any staff. Resid						
	forehead.	e right side of her					
	ioreneau.						
	Interview with t	the ADON on 3-22-13					
		ndicated she had					
		ent #18's care sheet					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: R0KF11

Facility ID: 000135

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155230	B. WING		03/22/2013
NAME OF I	PROVIDER OR SUPPLIE	R	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				HESTER BLVD	
ROSEBU	JD VILLAGE		RICHM	OND, IN 47374	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		ept within eye sight until			
		to lay down. The			
		ed the CNAs were			
	1 ' '	eview the care sheet			
		so they would know of			
		nade. The ADON			
		did not know why			
		was not within eyesight			
		e ADON wheeled			
	station at this t	down to the nursing			
	Station at this i	ume.			
	Peview of a de	ocument titled Fall			
		Program provided by			
		tor on 3/22/13 at 11:15			
	a.m., indicated				
		of American Seniors			
		o ensure residents			
		the facility will maintain			
		sical functioning			
		tablishment of physical,			
	_	and psychosocial			
		revent injury related to			
	falls.	, ,			
		Il Risk: 4. Charge			
		nmunicate the specific			
		for each resident to the			
	•	giver on each shift.			
	_	all event will be initiated			
	as soon as the	e resident has been			
	assessed and	cared for.			
	The report mu	st be completed in full			
	•	ntify possible root			
		ne fall and provide			
	immediate inte	erventions.			
i	i		I .	I	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: R0KF11

Facility ID: 000135

If continuation sheet Page 38 of 47

PRINTED: 04/15/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	OO OO	(X3) DATE COMPL		
ANDILLAN	OI CORRECTION	155230		LDING	00	03/22/	
		100200	B. WIN			03/22/	2010
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE HESTER BLVD		
ROSEBU	ID VILLAGE				OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-	e completed in the EMR					
	(electronic med						
	_	fall, any injuries,					
	interventions in	family notification and					
		nitiated. De discussed by the					
		y team the next					
		norning after the fall to					
	determine othe	_					
		prevent future falls.					
		provent fatare fane.					
	3.1-45(a)(2)						
	(4.)(4.)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: R0KF11

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Facility ID: 000135

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR		SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		155230	B. WIN			03/22/	2013
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				HESTER BLVD		
DOSEBII	D VILLAGE				OND, IN 47374		
					OND, IN 47374		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE		DATE
F000325	483.25(i)	NITION STATUS LINII ESS					
SS=D	UNAVOIDABLE	RITION STATUS UNLESS					
	-	ent's comprehensive					
		facility must ensure that a					
	resident -	naomity mast should that a					
	(1) Maintains acc	eptable parameters of					
	nutritional status,	such as body weight and					
	•	less the resident's clinical					
		trates that this is not					
	possible; and	ananautia diatuuban thana ia					
	(2) Receives a therapeutic diet when there is a nutritional problem.						
		rvation, interview and	F000325		F 325 MAINTAIN NUTRITION		04/10/2013
			1.00	0323	STATUS UNLESS		04/10/2013
	-	the facility failed to			UNAVOIDABLE Based on a	1	
	•	ment new interventions	resident's comprehensive assessment, the facility must ensure that a resident maintains		resident's comprehensive		
		vith weight loss for 1 of					
		iewed for weight loss			าร		
	of 5 who met th	ne criteria for weight			acceptable parameters of		
	loss. (Residen	t #50)			nutritional status, such as body		
					weight and protein levels, unle		
	Findings includ	e:			the resident's clinical condition		
	-				demonstrates that this is not possible; and receives a		
	The record of F	Resident #50 was			therapeutic diet when there is	а	
		20/13 at 11:15 a.m.			nutritional problem.	-	
		diagnoses included,			What corrective action(s) will	I	
		nited to, diabetes,			be accomplished for those		
					residents found to have beer	1	
		disease, Alzheimer's			affected by the deficient		
	=	eral renal artery			practice? * Resident #50 was		
	stenosis and re	enal insufficiency.			not harmed during the alleged		
					deficiency practice. * Resident #50 receives all dietary		
		MDS (Minimum Data			supplements as orderedby		
	Set), assessme	ent, dated 2/1/13,			physician. How will you ident	ifv	
	indicated BIMS	, (Brief Interview for			other residents having the		
	Mental Status).	7, a score of 8-12			potential to be affected by the	е	
	•	erate impairment of			same deficient practice and		
		ident #50's eating			what corrective action will be	•	
			1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: R0KF11

Facility ID: 000135

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155230	A. BUILDING B. WING 03/22/2013			2013	
			B. WIN		ADDRESS OFTW STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP CODE		
					HESTER BLVD		
ROSEBU	JD VILLAGE			RICHM	OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	indicated limite	ed assistance.			taken. * Residents who reside	e in	
					this facility have the potential t	ю	
	Decident #50's	care plan, dated			be affected by the alleged		
		•			deficient practice. * All staff w	/as	
		em, resident is now			inserviced by the Director of		
		ice Care. Resident			Nursing and/or designee on		
	leaves 25-50%	of meals creating risk			identifying risk for weight loss	in	
	for unintentiona	al weight loss.			residents on April 10, 2013.		
	Contributing fa	ctors diagnoses			*Dietary Manager and/or		
	1	eral renal artery			designee will conduct a facility audit on all tray cards to ensur		
	· ·	eimer's dementia,			accuracy by April 10, 2013 to	e	
		•			ensure residents are provided		
		disease and renal			with diet as prescribed by		
	insufficiency."				physician. What measures w	ill	
					be put into place or what		
	Resident #50's	physician orders,			systemic changes you will		
	dated 5/13/12,	"regular diet,			make to ensure that the		
		oohydrate/double			deficient practice does not		
		stitute," 1/10/13,			recur? *All Staff have been		
		depressant) 7.5 mg			inserviced by the Director of		
	1				Nursing and/or designee		
	,	r depression and			on identifying risk for weight lo	ss	
	· ·	nut butter and jelly			in residents on April 10, 2013.	* A	
	sandwich at be	edtime."			manager is assigned by		
					Executive Director and/or		
	Resident #50's	document titled			designee to each meal to iden	-	
	"weight record"	" indicated the			any changes in residents and/	or	
	following:				ensure all appropriate current interventions are carried out a	,	
	- 11/1/12, 129,	nounds			meals in dining room and roon	-	
					trays. *Dietary Manager and/o		
	- 12/3/12, 134,	•			designee will conduct a facility		
	- 1/2/13, 129, p				audit on all tray cards to ensur		
	- 2/1/13, 132, p	oounds			accuracy by April 10, 2013 to		
	- 3/5/13, 127, p	oounds			ensure residents are provided		
	- 3/19/13, 122,	pounds			with diet as prescribed by		
	_ ,,	•			physician. * Dietary Manager i	s	
	During an inter	view on 3/20/13 at			responsible for compliance		
	•				related to all interventions for		
		Dietary Manager			weight losses are implemented		
	indicated Resident #50 was not				Non-compliance with weight lo	oss	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
		155230	B. WIN			03/22/2013
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	R		1	HESTER BLVD	
ROSEBUD VILLAGE			1	OND, IN 47374		
NOOLDC	NOSEBOD VIELAGE			KICI IIVI	OND, IN 47374	
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	receiving a die	tary supplement.			interventions being implement	
					may result in further education	
	Resident #50's	dietary assessment,			and/or disciplinary action. Ho	
		indicated "March			will the corrective action(s) b	е
	· ·	ows gradual weight			monitored to ensure the	
		but stable. Resident			deficient practice will not rec	ur,
	1				i.e., what quality assurance program will be put into plac	92
		tted to Hospice for			* A Meal Service Observation	G:
		t to receive a regular			CQI tool will be utilized by	
	_	portions at breakfast			Director of Nursing and /or	
	and peanut bu	tter and jelly sandwich			designee weekly x 4 weeks,	
	at bedtime. W	ill add whole milk to			monthly x 2 months and quarte	erly
	meals when m	enued resident's intake			X1 for at least 6 months. * Au	dit
	has decreased	somewhat. Most			tools will be submitted to the C	· ·
		es 25-50% with			committee and action plans wi	II
	set-up."	C3 20 30 /0 With			be developed as needed if a	
	Set-up.				threshold of 90% is not met.	
					Rosebud Village respectfully	•
	_	ervation on 3/20/13 at			requests the state consider the following evidentiary information	•
	11:15 a.m., CN	IA #9 was cueing			be considered in deleting the	ווע
	Resident #50 t	o eat some of her			deficiency F 325. Rosebud Vill	ane
	lunch. Resider	nt #50 took a few bites			is requesting a paper IDR review	
	of her food and	CNA #9 took the fruit			The current 2567 statement of	
	from Resident	#50's tray and left it on			deficiencies omits pertinent	
		ble for later. Resident			facility information and therefo	re
		she wasn't hungry and			misrepresents the services	
					administered by the provider.	F
	did not eat any	more.			325 Nutrition Federal	
					Regulation states: Based on	а
	During an inter	view with the Dietary			resident's comprehensive	
	Manager on 3/	20/13 at 11:30 a.m.,			assessment, the facility mus	t
	the Dietary Ma	nager indicated the			ensure that a resident	
	1	ince Resident #50			§483.25(i)(1) Maintains	
		weight were, on 5/13/12			acceptable parameters of	
	_	portions, 11/29/11,			nutritional status, such as body weight and protein leve	Je
		and jelly sandwich at			unless the resident's clinical	
	l ·				condition demonstrates that	
		13 Remeron 7.5 mg			this is not possible; and	
	and 3/11/13 wl	nole milk at meals.			and is not possible, and	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155230		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/22/2013	
	PROVIDER OR SUPPLIEF		2050 C	ADDRESS, CITY, STATE, ZIP CODI HESTER BLVD IOND, IN 47374	E
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE COMPLETION
	11:50 a.m., Re have milk on h During an inter Manager on 3/ the Dietary Ma	ervation on 3/22/13 at sident #50 did not er lunch tray. view with the Dietary 22/13 at 11:57 a.m., nager indicated only receives milk on milk is on the menu.		\$483.25(i)(2) Receives a therapeutic diet when the nutritional problem. State Operations Manual Intersection of Guidelines for F 325 Acceparameters of nutritional sectors that reflect an individual's nutritional sectors adequate, relative to his/reverall condition and progue "Avoidable/Unavoidable" to maintain acceptable parameters of nutritional sectors and individuals means that resident did not maintain acceptable parameters of nutritional status even the facility had evaluated the resident's clinical condition nutritional risk factors; defined implemented interventhat are consistent with reneeds, goals and recognistandards of practice; mo and evaluated the impact interventions; and revised approaches as appropriate "Insidious weight loss" refigradual, unintended, progweight loss over time. End-of-Life Resident cho and clinical indications aff decisions about the use of feeding tube at the end-of resident at the end of life have an advance directive addressing his or her treat goals (or the resident's suor representative, in accowith State law, may have decision). Decreased appand altered hydration are	pretive pretive pretable preta

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
		155230	B. WING		03/22/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R		CHESTER BLVD	
DOSEDI	ROSEBUD VILLAGE			IOND, IN 47374	
KOSEBU	DD VILLAGE		KICITIV		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
IAU	REGULATORY	R LSC IDENTIFYING INFORMATION)	IAG	common at the end of life, and not require interventions other than for comfort. Multiple orga system failure may impair the body's capacity to accept or digest food or to utilize nutrient. Thus, the inability to maintain acceptable parameters of nutritional status for someone who is at the end-of-life or in the terminal stages of an illness of the measures, are provided based the resident's choices and a pertinent nutritional assessment. The facility can help to support intake, to the extent desired at feasible, based on the information from the assessment and on considering the resident's choices. If individualized approaches for end-of-life care are provided in accordance with care plan and the resident choices, then the failure to maintain acceptable parameter of nutritional status may be an expected outcome for resident with terminal conditions. The	ts. he hay e ht don nt. tt hod hition e th 's ers
				deficient practice statement states: Based on observation, interview, and record review, to facility failed to follow or	
				facility failed to follow or implement new interventions f resident with weight loss for 1	of 2
				residents reviewed for weight of 5 who met the criteria for	loss
				weight loss. (Resident #50). Evidence to Refute the Findi	na
				Resident 50 1. Resident #50	<u> </u>
				was admitted to the facility on	
				1	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	00	COMPLETED			
		155230	B. WING 03/22/2013				
	ROVIDER OR SUPPLIER		2050 C	ADDRESS, CITY, STATE, ZIP CODE HESTER BLVD IOND, IN 47374			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION		
				7/21/2009. Resident's prima diagnoses are bilateral renal artery stenosis, type II diabe hypertension, chronic renal insufficiency, carotid artery disease, history of constipati Alzheimer's dementia with behavioral disturbances, and insomnia. (Attachment A). Resident #50 dietary physici orders included the following regular diet with large breakt peanut butter and jelly sandrat bedtime, salt substitute peresident request and offer bedtime snack. (Attachment 3. Resident #50 nutritional assessments completed by Registered Dietician include following; meds, labs and vitamins reviewed by hospic orders to discontinue or char (Attachment C) 4. Resident (Attachment C) 5. Resident (Attachment D) 5. Resident (Attachment D) 5. Resident received an order for hospic services which states; may a resident to hospice, to keep resident comfortable, PRN medications, monitor pain, s mattress, may discontinue calcium supplement with vita D, may d/c CBC and LFT's Levery March and September March 8 th , 2013. (Attachment 6. Resident # 50 health was deteriorating as evidence from the social service notes, and nursing notes dated 2/6/13, 2/11/13, 3/07/13, and 3/20/1 (Attachment F) 7. The reco	ry Intes, Ites, It		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/22/2013
	ROVIDER OR SUPPLIER	.	STREET 2050 C	ADDRESS, CITY, STATE, ZIP COE CHESTER BLVD IOND, IN 47374	Ε
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPL DEFICIENCY)	LD BE COMPLETION
				reflects that Resident 50 experienced a 7 pound w loss between April 2012 a 2013. However all appropring measures were taken to this Resident was provide adequate nutrition and encouraged to consume snacks and fluids of her of (Attachment G). 8. Resifood intake is monitored evidence by daily vitals rewhich includes all of the meal intakes for the last a months to current date (Attachment H). 9. Resiflabs were monitored as eby routine labs (Attachment H). 9. Resiflabs were monitored as eby routine labs (Attachment H). Resident #50 annual nutritional assessment who completed and stated that resident's personal goal with that resident #50 ideal boweight is between 108-13 (Attachment K). Conclust Residents #50's weight a intake were being monitor Resident #50 experience unavoidable weight loss of the resident's deteriorating physical condition and the acceptance of participation of the resident had order of snacks. The facility made continuous dietary changinterventions to help the achieve their highest practical properties and the resident with assistant well being. The facility properties are sident with assistant well being. The facility properties are sident with assistant well being. The facility properties are sident with assistant well being. The facility properties are sident with assistant well being. The facility properties are sident with assistant well being. The facility properties are sident with assistant well being. The facility properties are sident with assistant well being. The facility properties are sident with assistant well being. The facility properties are sident with assistant well being. The facility properties are sident with assistant well being. The facility properties are sident with assistant well being.	reight and April priate ensure ed with ensure ensure ed with ensure ensur

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	OF CORRECTION	IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLET 03/22/20	ΓED	
	PROVIDER OR SUPPLIE JD VILLAGE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE	
IAU	REGULATORY OF	X LOC IDENTIF I ING INFURMATION)	IAU	eat. Therefore, Rosebud Vill does not believe it should habeen cited for F 325, and therefore requests F 325 be deleted. Thank you for your consideration. Joni Howell, F Executive Director	age ave	DATE	

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